

**Commonwealth of Massachusetts**  
**Center for Health Information & Analysis (CHIA)**  
**Non-Government Agency Application for Data**

**NOTE:** This application is to be used by all applicants, except Government Agencies, as defined in 957 CMR 5.02.

## I. GENERAL INFORMATION

APPLICANT INFORMATION	
Applicant Name:	
Title:	
Organization:	
Project Title:	
Date of Application:	
Project Objectives (240 character limit)	
Project Research Questions	1. 2. 3.

Please indicate if you are a Researcher, Payer, Provider or Provider Organization and you are seeking data pursuant to [957 CMR 5.04](#) (De-Identified Data) or [957 CMR 5.05](#) (Direct Patient Identifiers for Treatment or Coordination of Care).

<input type="radio"/> Researcher <input type="radio"/> Payer <input type="radio"/> Provider / Provider Organization	<input checked="" type="radio"/> 957 CMR 5.04 (De-identified Data) <input type="radio"/> 957 CMR 5.05 (Direct Patient Identifiers)
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All other requests are subject to [957 CMR 5.06](#).

## II. PROJECT SUMMARY

Briefly describe the purpose of your project and how you will use the CHIA data?

**III. FILES REQUESTED**

Please indicate the databases from which you seek data, the Level(s) and Year(s) of data sought.

DATABASE	Level 1 <sup>1</sup> or 2 <sup>2</sup>	Single or Multiple Use	Year(s) Of Data Requested Current Yrs. Available 2009 - 2011
<input type="checkbox"/> Medical Claims	<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2	Select... ▼	<input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011
<input type="checkbox"/> Pharmacy Claims	<input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2	Select... ▼	<input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011
<input type="checkbox"/> Dental Claims <input type="checkbox"/> Member Eligibility <input type="checkbox"/> Provider <input type="checkbox"/> Product	<input type="checkbox"/> Level 2 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 2	Select... ▼ Select... ▼ Select... ▼ Select... ▼	<input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011
<b>CASEMIX</b>	<b>Level 1 - 6</b>		<b>Fiscal Years Requested</b>
<b>Inpatient Discharge</b>	<input type="checkbox"/> Level 1 – No Identifiable Data Elements <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) <input type="checkbox"/> Level 4 – UHIN and UPN <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number		<u>1998-2012 Available</u> (limited data available 1989-1997)
<b>Outpatient Observation</b>	<input type="checkbox"/> Level 1 – No Identifiable Data Elements <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) <input type="checkbox"/> Level 4 – UHIN and UPN <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number		<u>2002-2011 Available</u>

<sup>1</sup> Level 1 Data: De-identified data containing information that does not identify an individual patient and with respect to which there is no reasonable basis to believe the data can be used to identify an individual patient. This data is de-identified using standards and methods required by HIPAA.

<sup>2</sup> Level 2 (and above) Data: Includes those data elements that pose a risk of re-identification of an individual patient.

<b>Emergency Department</b>	<input type="checkbox"/> Level 1 – No Identifiable Data Elements <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) <input type="checkbox"/> Level 4 – UHIN and UPN; Stated Reason for Visit <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number	<u>2000-2011 Available</u>
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**IV. REQUESTED DATA ELEMENTS [APCD]**

State and federal privacy laws limit the use of individually identifiable data to the minimum amount of data needed to accomplish a specific project objective. Please use the [APCD Data Specification Workbook](#) to identify which data elements you would like to request and attach this document to your application.

**V. REQUESTED DATA ELEMENTS [CASE MIX]**

Please use the CASE MIX DATA SPECIFICATION WORKBOOK to identify which deniable data elements (from Level 2 or above) you would like to request and attach this to your application.

**VI. MEDICAID DATA**

Federal law (42 USC 1396a(a)7) restricts the use of individually identifiable data of Medicaid recipients to uses that benefit the administration of the Medicaid program. If you are requesting Medicaid data from Level 2 or above, please describe in detail why your use of the data benefits the administration of the Medicaid program.

**VII. MEDICARE DATA**

Medicare data may be disseminated to state agencies and/or entities conducting research projects that are directed and partially funded by the state if such research projects would allow for a Privacy Board or an IRB to make the findings listed at 45 CFR 164.512(i)(2)(ii) if the anticipated data recipient were to apply for the data from CMS directly. If you are requesting Medicare data, please explain how your research project is directed and partially funded by the state and describe in detail why your proposed project meets the criteria set forth in 45 CFR 164.512(i)(2)(ii). Applicants must describe how they will use the data and inform CHIA where the data will be housed. CHIA must be informed if the data has been physically moved, transmitted, or disclosed.

**VIII. DIRECT PATIENT IDENTIFIERS<sup>3</sup>**

State and federal privacy laws may require the consent of Data Subjects prior to the release of any Direct Patient Identifiers. If you are requesting data that includes Direct Patient Identifiers, please provide documentation of patient consent or your basis for asserting that patient consent is not required.

<sup>3</sup> Direct Patient Identifiers. Personal information, such as name, social security number, and date of birth, that uniquely identifies an individual or that can be combined with other readily available information to uniquely identify an individual.

**IX. REQUESTS PURSUANT TO 957 CMR 5.04**

Payers, providers, provider organizations and researchers seeking access to Level 1 (de-identified) data are required to describe how they will use such data for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis or other administrative research purposes. Please provide this information below.

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**X. FILTERS**

If you are requesting APCD elements from Level 2 or above, describe any filters you are requesting to use in order to limit your request to the minimum set of records necessary to complete your project. (For example, you may only need individuals whose age is less than 21, claims for hospital services only, or only claims from small group projects.

APCD FILE	DATA ELEMENT(S) FOR WHICH FILTERS ARE REQUESTED	RANGE OF VALUES REQUESTED
Medical Claims		
Pharmacy Claims		
Dental Claims		
Membership Eligibility		
Provider		
Product		

**XI. PURPOSE AND INTENDED USE**

- Please explain why completing your project is in the public interest.

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- Attach** a brief (1-2 pages) description of your research methodology. (This description will not be posted on the internet.)
- Has your project received approval from your organization's Institutional Review Board (IRB)?

- ☐ Yes, and a copy of the approval letter is attached to this application.
- ☐ No, the IRB will review the project on \_\_\_\_\_.
- ☐ No, this project is not subject to IRB review.
- ☐ No, my organization does not have an IRB.

**XII. APPLICANT QUALIFICATIONS**

- Describe your qualifications to perform the research described or accomplish the intended use of CHIA data.

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2. Attach résumés or curriculum vitae of the applicant/principal investigator, key contributors, and of all individuals who will have access to the data. (These attachments will not be posted on the internet.)

### XIII. DATA LINKAGE AND FURTHER DATA ABSTRACTION

1. Does your project require linking the CHIA Data to another dataset? YES ☐ NO ☐
2. If yes, will the CHIA Data be linked to other patient level data or with aggregate data (e.g. Census data)?  
Patient Level Data ☐ Aggregate Data ☐
3. If yes, please identify all linkages proposed and explain the reasons(s) that the linkage is necessary to accomplish the purpose of the project.

4. If yes, please identify the specific steps you will take to prevent the identification of individual patients in the linked dataset.

### XIV. PUBLICATION / DISSEMINATION / RE-RELEASE

1. Describe your plans to publish or otherwise disclose CHIA Data, or any data derived or extracted from such data, in any paper, report, website, statistical tabulation, or similar document.

2. Will the results of your analysis be publicly available to any interested party? Please describe how an interested party will obtain your analysis and, if applicable, the amount of the fee.

3. Will you use the data for consulting purposes? YES ☐ NO ☐
4. Will you be selling standard report products using the data? YES ☐ NO ☐
5. Will you be selling a software product using the data? YES ☐ NO ☐

6. If you have answered “yes” to questions 3, 4 or 5, please describe the types of products, services or studies.

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**XV. USE OF AGENTS AND/OR CONTRACTORS**

Third-Party Vendors. Provide the following information for all agents and contractors who will work with the CHIA Data.

Company Name:	
Contact Person:	
Title:	
Address:	
Telephone Number:	
E-mail Address:	
Organization Website:	

1. Will the agent/contractor have access to the data at a location other than your location or in an off-site server and/or database?                      YES   ☐                      NO   ☐

2. Describe the tasks and products assigned to this agent or contractor for this project.

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3. Describe the qualifications of this agent or contractor to perform such tasks or deliver such products.

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4. Describe your oversight and monitoring of the activity and actions of this agent or subcontractor.

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**Information provided from this page forward will NOT be posted publicly on the internet.**

**XVI. APPLICANT CONTACT INFORMATION**

Applicant Name:	
Title:	
Organization:	
Address:	
Telephone Number:	
E-mail Address:	
E-mail Addresses of ALL Co-Investigators:	

**XVII. DATA SECURITY AND INTEGRITY**

(Information provided in this section is confidential and not a public record.)

Complete this section for each location where the data will be stored or accessed. If you plan to use an agent/contractor that has access to the data at a location other than your location or in an off-site server and/or database, the agent/contractor should complete this section.

1. Please identify and provide contact information for the person who will be responsible for data security.

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2. If your agency has a Written Information Security Program (WISP) or a data sharing agreement/ISA with CHIA that contains data security provisions, please attach the documents and refer to the applicable sections in your response to the questions below.
3. Specify the security measures you will take to prevent unauthorized access to or use of data, including information on access restrictions, handling and storage of data, physical security of the data, audit policies and capabilities, and breach notification policies.

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4. Describe how the original data media and subsequent copies of the data will be protected; how mainframe, server or PC data files will be protected; where and how work files are protected; how the data on PCs are protected from access; and how Internet enabled devices will be protected.

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5. Describe how you will ensure that data cannot be accessed by portable devices.

6. Describe any other relevant security and privacy provisions.

### **XVIII. DATA RETURN OR DESTRUCTION**

Applicants are required to attest that the original released CHIA Data and all copies of the CHIA Data used by the Applicant or its employees, contractors or agents will be destroyed upon completion of the project described in this Application. All data destruction must conform to the requirements of M.G.L. c. 93I. Specify the measures you will use to meet these requirements.

### **XIX. ASSURANCES**

Applicants requesting and receiving data from CHIA pursuant to 957 CMR 5.00 (“Data Recipients”) will be provided with data following the execution of a data use agreement that requires the Data Recipient to adhere to processes and procedures aimed at preventing unauthorized access, disclosure or use of data.

Data Recipients are further subject to the requirements and restrictions contained in applicable state and federal laws protecting privacy and data security, including but not limited to the Massachusetts Fair Information Practices Act, M.G.L. c. 66A; M.G.L. c. 93H (data breaches); and M.G.L. c. 93I (data destruction).

Data Recipients must notify CHIA of any unauthorized use or disclosure of CHIA data.

Signature:	
Printed Name:	
Title:	
Agency:	
Date:	